Healthy Children:
Health Care Coverage and Access for King County's Low-Income Kids

Children's Health Access Task Force
Final Report

August 17, 2006

King County

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

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August 17, 2006

King County Executive Ron Sims
701 Fifth Ave. Suite 3210
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Dear Executive Sims,

It has been an honor to co-chair the King County Children's Health Access Task Force from April to June 2006. Thank you for this opportunity to serve, and for your incredible vision and energy. We are especially proud that King County is taking a pro-active stance on this issue of providing better healthcare and dental care to children from low-income families.

With this letter we are transmitting the recommendations of the Task Force, which advises you to expand access and outreach activities for health care coverage immediately, and to create a Children's Health Initiative that will offer health coverage to children in low-income families in King County who are not eligible for state or federal programs. For Phase 1, in the remainder of 2006, we recommend targeting outreach to families who are currently uninsured yet eligible for state and federal health insurance programs. In Phase 2 in early 2007, we recommend launching a new health and dental coverage program for children in low-income and working poor families with incomes up to 300 percent of the federal poverty level. By 2010, we will reach a Phase 3 where the state achieves its pledge to cover all children in Washington State.

Bringing health care coverage and access to needed services to low-income King County children is the *Right Cause,* for the *Right Reasons;* it is on the *Right Scale* and solutions are needed *Right Now.* We need to start making smarter investments in health care services. It would be difficult to find anyone who would say that today's status quo healthcare is adequate or acceptable. Our current system often leads to the highest possible costs by failing to promote prevention or lower cost early interventions. The health burden of uninsured and under-insured children in King County is a burden that all of us bear in more ways than might be appreciated.

Bringing health care coverage and access to needed services to low-income King County children in this program is an opportunity to turn the page in King County. We have good reference models and lessons learned from some similar piloting efforts in counties in other states. Local expertise has been brought together in an energetic task force with a comprehensive knowledge of the healthcare system.

The scope of this program is appropriate because in King County we are addressing the health needs of a manageable number of children. This provides for a logistically efficient model to pilot health coverage solutions. This size program is more easily feathered into the existing healthcare system without disrupting other forms of coverage or services. Manageable scope also allows for accurate measurement and tracking of its effectiveness. This is especially important as it informs larger statewide strategies in accord with Governor Gregoire's 2010 goal to cover all children in Washington.

Once again, we were honored to serve as co-chairs of the King County Children's Health Access Task Force, and we and the rest of the Task Force are ready to work with you to assure that we do the best we can for our children's health. We close this letter with the quote you used in the "State of the County" address on May 22, 2006 when you spoke of your commitment to children's health:

> Many things we need can wait. The child cannot. Now is the time his bones are being formed, his blood is being made, his mind is being developed. To him we cannot say tomorrow, his name is today.
>
> *-Gabriela Mistral, Chilean poet, 1889-1957*

With appreciation,

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EXECUTIVE SUMMARY

An estimated 16,000 children living in King County (4%) have no health insurance, according to 2004 survey data. About half of these 16,000 uninsured children are eligible for existing publicly-funded insurance programs. After Public Health-Seattle & King County (PHSKC) conducted an internal study on uninsured low-income children in King County, County Executive Ron Sims concluded that the County has a unique opportunity. In partnership with the State of Washington, which has declared its intention to cover all children in the state by 2010, the County has begun work to design an innovative program to provide health and dental insurance coverage and access to a medical home – a regular source of healthcare that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective – for most of the 16,000 children uninsured in King County.

To make a difference in children's health, it is essential to have both health care coverage and a health care delivery system that is ready to provide early preventive services and link children to needed care. Recognizing this dynamic, in April 2006, King County Executive Sims convened a Children's Health Access Task Force (CHATF) of child health experts to advise King County on the creation of an innovative county-based children's health program. Dr. Maxine Hayes, the Washington State Health Officer, and Dr. Ben Danielson, the Medical Director at Odessa Brown Children's Clinic, co-chaired the Task Force, with support from Milliman consultants and actuaries who carried out actuarial and programmatic analyses of various program designs. The Task Force met three times between April and June 2006 and recommended the creation of a program that will dovetail with the State's 2010 goal and build on the innovative work of the King County Health Action Plan, such as the Kids Get Care program.

Task Force Recommendations

The Task Force recommends a phased approach to improving the health of low-income children, starting with an outreach and access phase in 2006, followed in 2007 by a health insurance program to fill in the "gap" left by current public coverage programs and culminating in 2010 with full statewide coverage.

Phase 1: Outreach and Access Improvement: The Task Force recommends investing funds to identify and sign up the estimated 8,000 low-income children eligible for existing publicly funded insurance programs by implementing a targeted access and outreach program, and connecting families to comprehensive preventive services including oral and mental health and a medical home.

Phase 2: "Gap" Insurance Program for Children: The Task Force recommends creating a basic gap medical and dental insurance program that would be offered to an estimated 5,000 children in families under 300 percent of the federal poverty level or immigrant children who are not eligible for existing public or private programs. These programs will be similar to existing publicly-funded health programs in terms of benefits, eligibility and cost, and have minimal cost sharing.

Phase 3: Consolidation with State Programs in 2010: Governor Gregoire has set a goal for the State of Washington that all children in the state will be covered by health insurance by 2010. By 2010, the King County program should either be consolidated into the state's coverage programs or the state should provide the financial resources to King County to continue this program as a component of the state's overall strategy.

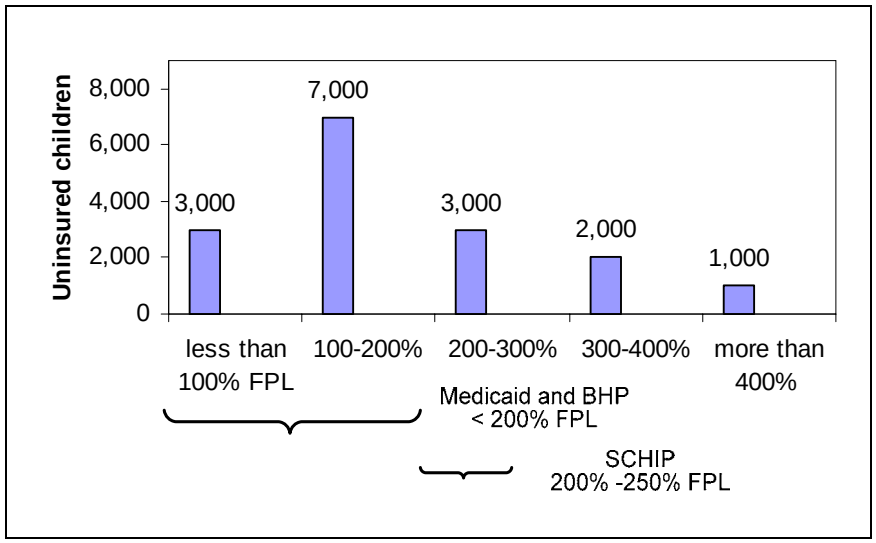
In addition, the Task Force recommends King County aggressively seek partners and funding opportunities, conduct a comprehensive evaluation of the initiative, coordinate efforts with the State of Washington's child health expansion efforts, and employ strategies that reward quality and efficiency that align with the goals of prevention and overall improved health status.

As next steps, the Task Force proposes that Task Force staff continue to finalize the programmatic and financial information necessary to move the proposed program through King County's decision process with the King County Council and to explore funding partnerships with foundations and private organizations. Concurrently, the Task Force recommends that two committees be established to steer the implementation process—an Outreach Committee, and an Operations and Policy Committee – to guide outreach strategies and provide general oversight and guidance, respectively, As the committees develop an implementation strategy, the Task Force strongly recommends they adopt innovative program design features and reimbursement strategies that promote the use of incentives to improve health status and align with the work of the Puget Sound Health Alliance.

BACKGROUND

An estimated 16,000 children in King County (4%) have no health insurance, according to 2004 survey data.[i] About half of these 16,000 uninsured children are eligible for existing programs: Medicaid, Washington State Children's Health Insurance Program (SCHIP) or Basic Health Plan (BHP) coverage. Medicaid covers about 460,000 children statewide below 200 percent of the federal poverty level (FPL). SCHIP covers about 11,000 children statewide from 200 percent to 250 percent of the FPL, and excludes immigrant children. Basic Health covers about 15,000 children living in Washington up to 200 percent of the FPL, with limited benefits, e.g. no dental or physical therapy, and substantial cost sharing.

Chart 1. Uninsured children by family income level in King County, 2004



Consequences of being uninsured and access to care barriers

Data show that uninsured children have less access to health care, are less likely to have a regular source of primary care or medical home and use medical and dental care less often compared to children who have insurance.[ii] Data also show that access to early preventive health care services can profoundly improve the trajectory of a child's health and well-being and readiness for school. Undiagnosed and untreated conditions that are amenable to control, cure, or prevention can affect

children's functioning and opportunities over the course of their lives.[iii] Even with presence of health insurance such as Medicaid coverage, access to proper health and dental services may be difficult.[iv] For example, only 31 percent of King County children under age six with Medicaid received any dental services in 2004.[v] Access improvement programs, such as the Access to Baby and Child Dentistry (ABCD), have worked with physicians, dentists and public health departments to increase the percentage of children receiving early preventive dental care. For more examples and citations, please see the feasibility study conducted by Public Health-Seattle & King County (PHSKC) in Appendix A.

Costs of the uninsured

The real costs of uninsured children far exceed the costs of providing coverage because children without health insurance eventually receive care from emergency rooms or other safety net providers, where the cost of care is often greater than it would have been if these children had received preventive care or early treatment for a health problem. Children's Hospital & Medical Center in Seattle provided $7.5 million or 2.1 percent of revenue in charity care in 2005. The Public Health-Seattle & King County clinics provided about 3,000 primary care visits to 1,900 uninsured children in 2005 at a cost of approximately $550,000. The community health centers in King County bear a higher financial burden; they provided care to an additional 7,000 to 9,000 uninsured children in 2005.[vi]

Improving Access and Coverage for Children

Insured children have better access to a medical home or regular source of care, and through medical homes have better access to appropriate and timely prevention, detection and care. The California Health Status Assessment Project found that children who were enrolled in health insurance improved their school performance ("paying attention in class" and "keeping up with the school activities") by 68 percent. Improved access and coverage also brings savings. In San Mateo County, California, the Child Health Initiative program was associated with a 58 percent decline in uninsured hospital stays for children in nearby hospitals.

CHILDREN'S HEALTH ACCESS TASK FORCE & ITS CHARGE

To make a difference in children's health, it is essential to have both health care coverage and a health care delivery system that is ready to provide early preventive services and link children to needed care. This is a key lesson learned as states such as Vermont and California have embarked on initiatives to improve the health of children. King County has a unique opportunity to create a program to extend coverage and access to children currently without health insurance in partnership with the State of Washington, which has declared an intention to cover all children in the state by 2010.

To explore the potential of such a program, King County Executive Sims called upon PHSKC to conduct a feasibility study to analyze the costs, potential savings, potential revenue sources, benefit package modeling, delivery system linkages and enhanced prevention services necessary to pilot an expansion of health coverage and access to all low-income children living in King County with incomes up to 300 percent of the FPL. That work was completed in the spring of 2006 (see Appendix A for Feasibility Study).

In April 2006, following review of the feasibility study findings, King County Executive Sims convened a Children's Health Access Task Force (CHATF) of child health experts to advise King County on the creation of an innovative county-based children's health program. (See Appendix B for invitation letter from Executive Sims). Dr. Maxine Hayes, the Washington State Health Officer, and Dr. Ben Danielson, the Medical Director at Odessa Brown Children's Clinic co-chaired the Task Force. The Task Force's work was supported by Milliman Consultants and Actuaries who carried out actuarial analyses of various program designs and by staff from the Office of King County Executive and the King County Health Action Plan (PHSKC), an existing coalition of public and private health care delivery system representatives, several of whom served on the Task Force.

The Task Force was asked to consider the feasibility study and to respond to the Executive's goals for a King County children's health program that would:

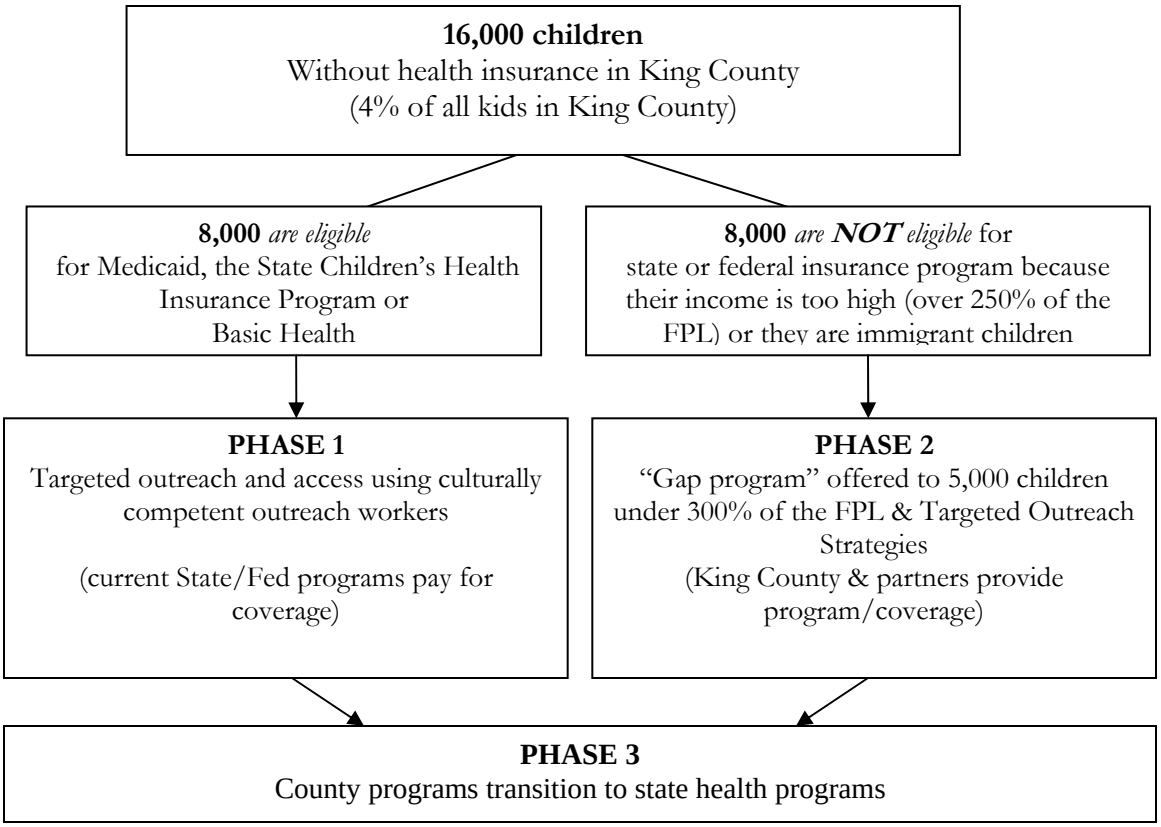
- Create an innovative program that can fill the existing gap in coverage for low-income children
- Design and implement a model program that will expand coverage and improve access on a cost effective basis

The Task Force has now completed its work and what follows are their recommendations.

RECOMMENDATIONS

The Task Force recommends that King County implement a phased in approach to improving the health of low-income children, starting with an outreach and access phase in 2006 and following in 2007 with a health insurance program to fill in the "gap" left by current public coverage programs (see Figure 1 below). A third phase will ensue as the County program transitions into the state children's coverage expansions.

Figure 1. King County's Child Health Coverage



Phase 1: Outreach and Access Improvement Elements

The Task Force recommends investing funds to identify low-income children eligible for existing publicly funded insurance programs by implementing a targeted access and outreach program, beginning in Fall 2006. Strategies include funding new outreach staff and community health workers who are trusted communicators to help sign up the estimated 8,000 children for the coverage they qualify for, and to connect them to comprehensive preventive services including oral and mental health and a medical home. This investment is projected to connect the majority of children eligible for Medicaid and SCHIP to a medical home and health insurance.

Also included in Phase 1 are the start up costs of the gap insurance program, including hiring a program manager, writing a request for proposals for health plans to cover children in 2007, funding for a rigorous evaluation, and establishing operational expertise for processing applications from families.

Phase 2: "Gap" Insurance Program for Children

Beginning in 2007, the Task Force recommends creating a gap insurance program that would be offered to 5,000 children in families under 300 percent of the FPL or immigrant children who are not eligible for existing public or private programs. Children in families over 300 percent of the FPL are not eligible for this gap insurance program. Final enrollment targets will be determined by the level of funding available to the new program.

The Task Force recommends that the new King County gap coverage program offer similar health and dental benefits as Washington State's Healthy Options (Medicaid) benefits for children in families with incomes up to 300 percent of the FPL ($49,800 for a family of three, $60,000 for a family of four). Cost sharing is imposed for families with incomes between 200 and 300 percent of the FPL but not for families with incomes below 200 percent of the FPL, except for a modest copayment for brand name prescription drugs. As program staff talk to families about the new

program, it is expected that they will find an equal or larger number of families eligible for current coverage programs.

Details about the access improvement elements, eligibility, benefits, and cost sharing levels recommended by the Task Force follow in tabular format, starting on page 8. The estimated actuarial costs of the medical and dental program models are as follows:

Proposed Medical and Dental Benefit Plans for King County Gap Insurance Program	Per Member Per Month Net Claim Cost
Medical benefit plan for children 200 – 300 percent of FPL	$76.38
Medical benefit plan for children below 200 percent of FPL	$84.28
Dental benefit plan for children under 300 percent of FPL	$28.03

For Milliman's detailed actuarial analysis see Appendix C.

Related to Phase 1 and Phase 2, the Task Force recommends a number of general programmatic components be employed:

- **Seek partners and funding opportunities.** King County should partner with the State of Washington and should aggressively solicit financial support from local and national private organizations and foundations. The recommended two-phase approach will not succeed without the involvement and support of local stakeholders. When implemented, Phase 1 and Phase 2 will provide immeasurable benefits to uninsured and underinsured children as well as the entire King County community.

- **Coordinate and collaborate with the Governor's Office and State.** King County should work closely with the Governor's Office and the State of Washington to ensure that the county's program will segue effectively into the upcoming state initiative. Child health will only make significant improvements if local, state and national efforts and strategies are coordinated and complement, not conflict, with each other.

- **Conduct a comprehensive evaluation of Phases 1 and 2.** King County's Children's Health Initiative should dedicate sufficient resources and funds to conduct a comprehensive evaluation of the different programmatic components. Being able to demonstrate improvement based on performance assessment will be a necessity for the phased approach to maximize its operational effectiveness and stay within budget. Equally important, performance and outcome results will inform the State's effort as it develops its strategy to cover all kids in 2010. For example, potential performance measures of success for Phase 1 would include the number of accepted applications for Medicaid, SCHIP and other publicly funded insurance, the number of new children with a regular source of medical and dental care, and the number of trained community agency staff e.g. child care workers. For Phase 2, promising measures include the number of new children with coverage, the number of new children with a regular source of medical and dental care, the number of children up-to-date with well child visits, the number of children up-to-date with immunizations, reductions in emergency room visits, reductions in unnecessary hospitalizations, reduced access barriers, and others.
- **Employ strategies that reward quality and efficiency that align with the goals of prevention.** King County's Children's Health Initiative, through its Policy Committee, should pursue connections with the Puget Sound Health Alliance to reward providers who provide preventive care and quality health care services to children that lead to improved health status.[1] The Puget Sound Health Alliance is a regional nonprofit founded and led by the King County Executive and in which King County is a major participant, to improve the quality of health care in the Puget Sound region.

Phase 3: Consolidation with State Programs in 2010

In Phase 3, the King County children's coverage programs will segue into the state program expansions. By 2010, the King County program should either be consolidated into the state's coverage programs or the state should provide the financial resources to King County to continue this program as a component of the state's overall strategy.

[1] The Alliance in December 2005 adopted the Institute of Medicine (IOM) starter set of measures. There are at least three dozen pediatric or child-related measures in the IOM starter set for pre-natal care, childbirth, neonatal care, childhood wellness and immunizations, childhood access to care, adolescent immunizations, pediatric asthma care, pediatric upper respiratory infection (URI) treatment, pediatric pharyngitis care, and parents' satisfaction with their children's health care.

Outreach and Access Improvement Elements

Purpose	Proposed Design	Goal
Phase 1: In the Community (Beginning Fall 2006): Outreach and Access Improvement Elements		
Promote advantages of prevention and assist families to enroll in coverage and access needed care	**Outreach Teams** Create four teams consisting of an application worker, community health worker and health educator Teams in each of four geographically targeted areas: • East King County • Seattle, White Center and North King County • South King County—Des Moines to Renton • South King County—Federal Way, Kent and Auburn	Increase coverage rates and early access to health care for low income and new immigrant populations in targeted areas as measured by increases in enrollees and children with medical and dental homes. Increase the focus on the advantages of prevention, especially among cultures in which preventive care is not accessed, to increase the rates of immunizations, well-child checks, developmental screening, early oral health exams, fluoride varnishes, and sealants. Find children eligible but not enrolled for current programs in '06, and for the new county gap program in '07 and assist with enrollment, linkage to a health care home, and navigating the health care system Provide culturally effective, tailored health messages in enrollees' first language when necessary (including translated materials). Additional target populations include at-risk children such as homeless youth and those in detention centers Teach families and community staff who work with children about the benefits of preventive care

Phase 2: In the Clinic (Beginning 2007): Care Coordination and Behavioral Health		
Link families to needed wrap around services and promote integrated preventive care	**Care Coordination** Hire one Patient Care Coordinator per 2,000 children at one or multiple health care provider sites. Staff four sites in 2007 and, pending evaluation of the cost effectiveness of this model, seven sites in 2008. Patient Care Coordinators provide a single point of contact for community agency staff and families. They assist with securing needed preventive care, chronic care, wrap around services, referrals, and follow-up care.	Care Coordinators can assist clinics to increase well child visits by 41%, oral health screens by 104% and developmental screenings 72-fold.

Eligibility and Benefits

	Proposed Design	Rationale
Phase 2 (January 2007): "Gap" Insurance Program for Children		
Age	Up to 19	Same as Medicaid and SCHIP
Residency	King County residents	Same as California county programs
Income	• Children in families between 200%-300% of FPL Family of 2: $26,400 – $39,600 Family of 3: $33,200 - $49,800 Family of 4: $40,000 - $60,000 • Children not eligible for existing insurance programs due to immigration status (0-300% of FPL)	All but one of the California county programs extend to 300%; the goal of the gap program is to provide insurance to lower-income middle-class families, not to subsidize those families who are able to afford employer-based coverage.
Other	Uninsured children ineligible for other health care coverage	
Waiting period protection (the period of time during which must be uninsured before enrolling)	3 months	Los Angeles (CA) has 3 month waiting period. After 2 years there is very little evidence "crowd out," i.e. when enrollees drop private health insurance and the public program is thought of as "crowding out" private coverage (one out of 2,000 persons who applied previously had employer-based private coverage). San Mateo (CA) has 6 months. There is little evidence of crowd out from private insurance. New Jersey over the last 5 years has lowered their crowd out provision from 12 to 6 to 3 months because there has very little evidence of crowd out.
Pre-existing condition waiting period	None for general population, but 9 months for transplants, lipid storage diseases, malignancy, hemophilia and congenital malformations	This provision is imposed so that the new gap program does not create an incentive for families living outside King County with severely ill children to move. The Task Force acknowledges that this provision is not

	Proposed Design	Rationale
		consistent with the goal of expanding access and coverage to children, but feels the need to have this rule in place to keep premiums affordable and to retain the intention of expanding coverage to King County families. This provision will enable children to get routine care and treatment for common conditions like asthma, therefore making it attractive for children to join without putting the program in financial strain.
Medical	Same as Medicaid	
Dental	Same as fee-for-service Medical Assistance Administration (MAA); added Access to Baby and Child Dentistry cost additions	The ABCD Program, now in 25 WA counties, has been shown to be effective in increasing the number of young children receiving early preventive services On average, ABCD-trained dentists receive an additional 10-30% reimbursement for preventive services
Vision	Same as fee-for-service Medicaid	
Mental health	24 outpatient visits 30 inpatient days Comparable to Medicaid	Under Medicaid, enrollees receive up to 12 outpatient visits through their managed care plan and if they need further services these are obtained through the Regional Support Networks, (RSN), without standard visit or day limits. The RSNs have severely limited capacity to serve new patients, especially those with mild to moderate mental health conditions who do not qualify as severely emotionally disturbed. The Task Force felt that a 24 visit and 30 inpatient day benefit was comparable and probably slightly less comprehensive than Medicaid mental health coverage, but that it was affordable and would meet the needs of most families. The Task Force supports an innovative delivery side strategy placing mental health specialists in the clinic in order to increase access for children needing mild to moderate mental

	Proposed Design	Rationale
		health care—a need that is not adequately met by the RSNs.
Substance abuse services	Same as Medicaid or up to a specific dollar limit	

Proposed Cost Sharing Features

	Below 200% FPL	Between 200% - 300% FPL	Rationale
Monthly Premiums	No	$15 per child per month, $45 max per family A hardship fund for premium assistance also will be created.	***Below 200% of FPL*** • Medicaid does not have premiums. • The families of these eligible children do not have the means to pay premiums. ***Between 200%-300% of FPL*** • WA SCHIP program premium is $15. • Aligns with program goals of simplicity (as it is the same premium as SCHIP). • It is a reasonable and affordable amount substantially lower than 5% of income for those families who are between 200-300% of FPL. • A $15 premium is typical for other children's health insurance programs for children of the same income. San Mateo (CA) has a $6 premium per child per month for 200-250% and $12 per child per month for 251-300%. Illinois is proposing a $40 premium ($80 max) for this income level.
Deductible	$0	$0	Medicaid & SCHIP do not have a deductible.
Preventive visits	$0	$0	Medicaid & SCHIP do not have copayments for preventive care. The Task Force wants to encourage preventive care, not discourage it.

	Below 200% FPL	Between 200% - 300% FPL	Rationale
Office visits copayments	$0	$15	***Below 200% of FPL*** • No copay currently exists under Medicaid/Healthy Options. • Copayments lead to poorer health for those with low incomes (low incomes = below 200% FPL). Among low-income adults and children, health status was considerably worse for those who had to make copayments than for those who did not (RAND study). ***Between 200%-300% of FPL*** • The Task Force believes lower-income middle class families above 250% of FPL have the means to afford a modest copayment for office visits. • A $5 and $10 copayment was dismissed because the administrative costs to process the payment are almost as high as the copayment amount.
Outpatient, radiology, lab, etc.	$0	$0	Medicaid & SCHIP do not charge copayments for outpatient, radiology, etc.
Inpatient hospital	$0	$0	Medicaid & SCHIP do not charge copayments for inpatient hospital visits.
Emergency room visit	$0	$25	***Below 200% of FPL*** • No copay currently exists under Medicaid/Healthy Options. A $5 or modest ER copay was dismissed due to the administrative costs to process the payment. ***Between 200%-300% of FPL*** • The Task Force overall recommended a modest ER copay to encourage preventive care and appropriate ER use.

	Below 200% FPL	Between 200% - 300% FPL	Rationale
Prescription drugs	$0 generics; $10 brand name	$0 generics; $10 brand name	The Task Force advises a $0 copay on generics and modest copay on brand name drugs to incent use of generics.

PROPOSED IMPLEMENTATION PLAN

The Task Force has provided the framework for a comprehensive program that will bring health care to thousands of children in King County. Now that the framework is complete, the Task Force recommends that PHSKC staff begin to plan the implementation process described below. The goal is to have the program ready to go once the final policy and funding decisions are made. The Task Force recognizes that this report is a recommendation to the King County Executive and that implementation requires legislative and budgetary action by the Executive and the King County Council. Therefore, while the Task Force strongly recommends that King County implement the program in accordance with the framework described in the report, we understand that the Executive and the Council may need to adjust certain elements or the timeline as the program is enacted.

Phase 1: October – December 2006

Identifying Children Eligible for Existing Programs

Successful implementation of the enhanced outreach and access component of the system calls for staff work to proceed with program design tasks. To bring eligible children into existing health insurance programs during fall and early winter of 2006, PHSKC will convene an Outreach Committee in the summer to begin collaborating with staff on implementation planning for the Access Improvement design. The Committee will assist in determining the most effective methods for:

- Identifying the optimal locations for community health educators, community health workers, and outreach workers

- Establishing the necessary connections with community health providers, Department of Social and Health Services staff, social service agencies, and other entities that serve families

- Determining the appropriate sequencing for adding outreach and access capacity

- Developing evaluation criteria and outcome measures that will be used to assess effectiveness for the Access Improvement component.

Designing Program Operations

The program design for Phase 1 calls for both locating and enrolling children in existing health coverage programs for which they are eligible. The Access Improvement efforts outlined above will identify these children and the actual enrollment of eligible children into these programs must follow as the next step. In addition to the enrollment process, there are a variety of other operational issues to address in order to move forward with Phase 1, including turning the Task Force's recommendations into an operational plan, writing a request for proposals for the health plans that will cover uninsured children in Phase 2, preparing pre-launch promotional activities, collecting baseline evaluation data, and establishing administrative procedures for handling applications.

Phase 2: Coverage and Improved Access for Low-Income Children - January 2007

Identifying Children for the New Program

Running parallel to its work on Phase 1, the Outreach Committee will begin work on elements that are essential for the successful roll-out of Phase 2. While much of the Committee's Phase 1 access improvement work will carry over to Phase 2, additional issues and general guidance will need to be addressed in order to identify children eligible for enrollment in the county's new health insurance program. For example, the Committee will assist in designing methods to address the following issues:

- Linking the program implementation for children involved in Phase 1 of the program to the additional children obtaining coverage during Phase 2

- Defining the outcome measures that will assess the effectiveness of the Phase 2 Access Improvement initiatives.

Defining Program Operations and Policy

The continued participation of many of the Task Force members and the knowledge and expertise that they bring will be important as the program design is refined, and during the implementation of the new program. PHSKC should convene an Operations and Policy Committee to assist staff in moving the program from the drawing board to the field. Among the issues the Committee will address, the following are particularly important:

- Guiding the Children's Health Initiative to ensure the initiative meets programmatic goals and financial guidelines

- Recruiting collaborators and funding partners and articulating the roles that they will play, and defining how these roles fit together, including the participating health plans, Public Health-Seattle & King County, the community clinics, other primary care providers, DSHS, etc.

- Collaborating with the Puget Sound Health Alliance to promote and reward quality health care such as preventive care and improved health status

- Identifying an overall evaluation plan and outcome measures, e.g. improvement in prevention and mental health that will track the effectiveness of the program in improving the ability of low-income families to access health care for their children

Phase 3: Coordinating with State Children's Coverage Expansions

The Task Force recommends continued collaboration and coordination with state efforts to cover all children by 2010. It is the intention of the Task Force that program features of interest to the

state could be piloted in the King County program. Consequently, evaluation activities will be critical for the County initiative to demonstrate value for the state process.

Next Steps

As the implementation planning moves forward, the Task Force proposes that Task Force staff continue to finalize the programmatic and financial information necessary to move the proposed program through King County's decision-making process. As stated above, staff should stay in close communication with the Governor's Office and other state leaders to ensure that the King County program creates a strong foundation for future initiatives to expand health care coverage for low-income children.

ENDNOTES

[i] 2004v3M Washington State Population Survey.

[ii] Institute of Medicine (IOM). 2002. *Health Insurance is a Family Matter*. Washington, DC: National Academy Press.

[iii] Forest, Christopher and A. Riley. September/October 2004. "Childhood Origins of Adult Health: A Basis For Life-Course Health Policy." *Health Affairs* 23 (5): 155-164.

[iv] Rosenbach, Margo, C. Irvin, R. Coulam. 1999. "Access for Low-income Children: Is Health Insurance Enough?" *Pediatrics* 103 (6): 1167-1175.

[v] Fiscal Year 2004 Medicaid Utilization Report.

[vi] 2005 Year End Demographic Snapshot: Primary Medical Care Patients, Prepared by Tim Burak, February 23, 2006, Public Health -S&KC Community Health Center Partnerships Program.